Choices for Care - Moderate Needs Group
Annual Reassessment

Individual Name:_____ SS#_____
ICD-9 Code:_____

Requested Start Date: _____
The above individual continues to meet the clinical and financial criteria for the Choices for Care, Moderate Needs services. The following services will be provided:
*(Check **all** services that apply and make note of any changes to these services)*

☐ **Case Management** – Limited to up to 12 hrs/yr @ $67.44/hr
Agency/Provider Name: _____

☐ **Homemaker** – Limited to up to 6 hrs/wk @ $18.68/hr
Agency/Provider Name: _____

☐ **Adult Day** – Limited to up to 30 hrs/wk @ $15/hr
Agency/Provider Name: _____

***NOTE: Actual service hours will be determined by service provider's assessment and based on need.**

Case Manager Name: _____

Agency Name: _____ Phone: _____

_____ _____
Signature *Date*

DAIL Authorization

Start Date: _____ TO End Date: _____

_____ _____
DAIL Authorized Signature Date

Copy to individual and providers.

Case Manager submits form to DAIL Waterbury for Authorization. Include: release of information, ILA,, assessment, financial worksheet, clinical worksheets, and checklist for annual reassessment.
Mail to Moderate Needs Coordinator, 103 South Main Street, Weeks 2, Waterbury, VT 05671-1601